HEALTH QUESTIONNAIRE

Please complete the details below and submit it to the reception desk.

Personal Information

First name (Given name)	Middle name	Last Name (Family name)
Nationality	Date of Birth (mm/dd/yyyy)	Gender M ☐ F ☐

Passport Number	
Resident Registration Number (ID No.)	
Company / Department Employee ☐ Family ☐	
Tel. (Cell phone)	
Tel. (Home)	
Preferred mode of result collection	☐ visit ☐ mail ☐ e-mail
E-mail	
Current address	

For women

The examination today includes radiologcial test that could harm your fetus.

1. Are you married? Y☐ N☐
2. Do you have possibility to be pregnant? Y☐ N☐
3. Are you doing breast-feeding? Y☐ N☐
4. Do you consent for radiological exam? Y☐ N☐
5. When did your last period start?
   _____ (mm/ dd / yyyy)

※ For the benficiaries of health check up program by National Health Insurance Corporation:
Do you agree to be charged by this hospital? ☐ Yes ☐ No Name: _____ (Signature)

Consent for the Collection and use personal Information

1. Korea Medical Foundation shall collect and use your personal information for the purpose of providing;
   a) Health screening b) Service including follow-up care and referral (eg. SMS, e-mail service)
   c) Membership service (eg. appointments)
   d) Information under relevant law such as Medical Service Act.
2. Range of information collected : Name, resident registration number, address, phone number (home and mobile), e-mail, company name, department, position, and medical results
3. The length information use and possession : 10 years
4. Your personal information will be solely used under the "Personal Information Protection Act" within the scope of confidentiality as a "Medical Law". It will never be used for other purposes, or will be provided to other facilities. (But, when you receive dental care in Lee's Fresh Dental Clinic which cooperates with Korea Medical Foundation, only limited information for an appointment will be shared.)
5. Personal information shall be shared within Korea Medical Foundation for purposes including appointments, treatment, after-service, consultation, and billing.

I hereby consent to collection and use of my personal information as above.

Date: (mm/dd/yyyy)

Name: (Signature)

INSTRUCTIONS FOR HEALTH EXAMINATION

General Instructions for check up

1. Have a light dinner the day before check up and fast after 9pm.
2. Avoid drinking, smoking and fatigue. Sleep adequately.
3. Do not have breakfast including water, gum, cigarette, and juice in the morning of the examination day.
4. For accurate examination, those who are scheduled for prostate/pelvis ultrasound examination come to the hospital holding urine after the first urine in the morning.
5. Medications for hypertension, thyroid conditions, and heart conditions are permitted with a minimum amount of water in the early morning of examination day.
6. If you are scheduled for UGI (Upper gastrointestinal series), medications intake is allowed after check up has been completed.
7. If you are taking medications for diabetes, please take the medication after the check up has been completed.
8. If you are scheduled for sedation endoscopy, please use public transportation since you won't be able to drive afterwards.
9. Do not carry any valuables, and refrain from bring children.
10. If you are under treatment or taking medication for any medical or physical condition, please consult a physician in advance.
11. If you have dentures or shaking teeth, this could interfere with stomach endoscopy.

Instructions for Female

1. Please receive the health checkup between 5-15 days after your period.
2. If you could be pregnant or if you are breastfeeding, please consult a physician before the examination.

Instructions for Pelvic ultrasound (Prostate / Uterus & Ovaries Ultrasound)

1. Do not void prior to the ultrasound examination. The test requires a full bladder for best results.

Instructions for a stool sample	Directions to collect a stool sample
1. Bring stool sample on the day of examination. 2. Store the collected stool sample in a cool place. 3. If you are on period, please make sure that the blood does not get mixed with your stool sample.	1. Twist the green lid to open the container. 2. In order to get the stool sample, swipe the stool with the stick attached to the lid, or put the stick inside of the stool. 3. Put the stick inside the container, close the lid, and shake the container vertically several times. 4. Place the container in a plastic bag, and bring it on the day of examination.

Checklist for Health Examination

Please complete the following questions about your current condition by checking the appropriate box.
Answers must be provided for all questions so the information will be reported correctly.

Medical History

1. Have you been diagnosed with any of the following diseases or are you currently on a treatment?

	Diagnosed	Being Treated
Brain stroke / Paralysis	☐	☐
Heart diseases (Heart attack)	☐	☐
Hypertension	☐	☐
Diabetes	☐	☐
Dyslipidemia	☐	☐
Tuberculosis	☐	☐
Other (cancer)	☐	☐

2. Has anyone in your family suffered or died from the following disease?

	Brain stroke	Heart disease	Hyper tension	Diabetes	Other (cancer)
Yes	☐	☐	☐	☐	☐

3. Are you a Hepatitis B virus antigen carrier?
☐ Yes ☐ No ☐ I don't know

Smoking

4-1. Have you ever smoked over 5 packs of tabacco (100 cigarettes) in your life?
☐ No, I never smoked (Go to the Question 5)
☐ Yes, I used to smoke but quit (Go to the Question 4-2)
☐ Yes, I'm still smoking (Go to the Question 4-3)

4-2. If you used to smoke but you are not smoking now, please answer the following.
① For how many years had you smoked? _____ years
② How many cigarettes in a typical day did you smoke before you quit? _____ cigaretts

4-3. If you are still smoking, please answer the following.
① How long have you been smoking ? _____ years
② How many cigarettes on average do you smoke in a typical day? _____ cigaretts

Alcohol

5-1. How many times a week do you usually drink?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

5-2. When you drink, how much do you usually drink? (Please answer with 'glass(es)' regardless of the type of the drink. One cup of beer (355cc) is equal to 1.6 glasses of beer) _____ glass(es)

Exercising

6-1. During the last week, how many days did you exercise vigorously for over 20 minutes until you were almost out of breath? (eg. running, aerobics, cycling in high speed, or mountain hiking, etc.)
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

6-2. During the last week, how many days did you exercise in a moderate level for more than 30 minutes until you had to breath a little faster than usual? (e.g. fast walking, tennis, or cleaning, etc.)
※ except the relevant answer from 6-1
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

6-3. During the last week, how many days did you walk for the total of 30 minutes or more in a day including 10 minute walks each time? (e.g. light exercise, walk to the work or walk for leisure, etc.)
※ except the relevant answer from 6-1 and 6-2
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Cognitive functions
(Only answer if you are 66 or 74 years old)

7. Please complete the following questions about current cognitive condition compared to last year.

	No	Occasionally	Yes
7-1. Compared to friends or other people, the memory is worse than others.	☐	☐	☐
7-2. Compared to last year, the memory is worse than before.	☐	☐	☐
7-3. The memory can interfere with handling an important matter.	☐	☐	☐
7-4 Has anyone noticed you with short memory?	☐	☐	☐
7-5. Do you have some difficulties to perform an daily chores that you used to do well before?	☐	☐	☐

Emotional status (Only answer if you are 40 years old)

8. Please answer the frequency you experience emotionally during the last week.
(1: Hardly ever / 2: Not too often / 3: Sometimes / 4: Always)

During the last week I,	1	2	3	4
8-1 was annoyed and bothered by things that were not before.	☐	☐	☐	☐
8-2. didn't want to eat and even lost appetite	☐	☐	☐	☐
8-3. felt sad even when someone tried to help me.	☐	☐	☐	☐
8-4. felt depressed.	☐	☐	☐	☐

Checklist for Cancer Examination

Please complete the following questions about your current condition by checking the appropriate box.
Answers must be provided for all questions so the information will be reported correctly.

Cancer

1. Do you have any uncomfortable areas in your body?
   - ☐ Yes (symptom:)
   - ☐ No

2. In the last six months, have you experienced a weight decrease exceeding 5kg without any specific reasons?
   - ☐ No
   - ☐ Yes (total weight loss: _____ kg)

3. Do you have any family members including yourself who have cancer?
   (1: you / 2: parents / 3: brother / 4: sister / 5: kids)

Type of cancer	No	No idea	Yes				
			1	2	3	4	5
Stomach cancer	☐	☐	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐	☐	☐
Colon cancer	☐	☐	☐	☐	☐	☐	☐
Hapatoma	☐	☐	☐	☐	☐	☐	☐
Cervical cancer	☐	☐	☐	☐	☐	☐	☐
Other ( )	☐	☐	☐	☐	☐	☐	☐

4. Were you ever examined on the followings?

Examination		Last examined			
		over 10 yrs ago or none	within 1 year	between 1~2yrs	between 2~10yrs
Stomach cancer	UGI (X-ray)	☐	☐	☐	☐
	Gastroscopy	☐	☐	☐	☐
Breast cancer	Mammogram	☐	☐	☐	☐
Colon cancer	Fecal Occult Blood Test	☐	☐	☐	☐
	Double contrast barium enema	☐	☐	☐	☐
	Colonoscopy	☐	☐	☐	☐
Cervical cancer	Pap smear	☐	☐	☐	☐
Liver cancer	Liver ultrasound	none	≤ 6 months	6 ~ 12 months	≥ 1yr
		☐	☐	☐	☐

Stomach Cancer, Colorectal Cancer, and Hepatoma

5. Do you currently have, or have you ever been diagnosed with any stomach disease below?
   - ☐ Stomach ulcer
   - ☐ Atrophic gastritis
   - ☐ Intestinal metaplasia
   - ☐ Polyps
   - ☐ Others
   - ☐ None

Stomach Cancer, Colorectal Cancer, and Hepatoma

6. Do you currently have, or have you ever been diagnosed with colon/ anus conditions below?
   - ☐ Polyps
   - ☐ Ulcerative colitis
   - ☐ Crohn's disease
   - ☐ Hemorrhoid
   - ☐ Other
   - ☐ None

7. Do you have any liver disease?
   - ☐ Hepatitis B carrier
   - ☐ Chronic hepatitis B
   - ☐ Chronic hepatitis C
   - ☐ Cirrhosis
   - ☐ Others
   - ☐ None

For women only (Breast and Cervical cancer)

8. When was your first menstrual period?
   - ① at the age of _____
   - ② I have never started my period yet.

9. Do you still have menstrual period ?
   - ☐ Yes
   - ☐ Hysterectomy (remove cervix or uterus)
   - ☐ Menopause (age:)

10. Have you ever taken on a hormone replacement therapy to alleviate menopausal symptoms after menopause?
   - ☐ Never
   - ☐ Taking less 2 years
   - ☐ Between 2 and 5 years
   - ☐ More than 5 years
   - ☐ I don't know

11. How many children have you ever given a birth?
   - ☐ 1 child
   - ☐ More than 2
   - ☐ No child

12. How long did you breast-feeding your child?
   - ☐ Less than 6 months
   - ☐ Between 6 and 12 months
   - ☐ More than 1 year
   - ☐ None

13. Have you ever been diagnosed with a benign breast tumor? (Benign tumor is Not a cancer, just a tumor)
   - ☐ Yes
   - ☐ No
   - ☐ I don't know

14. Have you ever taken, or are you currently taking a contraceptive?
   - ☐ Never
   - ☐ ≤ 1 year
   - ☐ Over 1 year
   - ☐ No idea

Please mark all of the gynecological symptoms that you are currently experiencing.
   - ☐ No symptoms
   - ☐ Back pain
   - ☐ Lower abdominal pain
   - ☐ Severe period pain
   - ☐ No period (amenorrhea)
   - ☐ Itchiness in genitalia
   - ☐ Bleeding after a sexual intercourse
   - ☐ Bleeding except period
   - ☐ Pain when urinating
   - ☐ Discharges from genitalia
   - ☐ Hot flush
   - ☐ Frequent Urination
   - ☐ Others ( )
   - ☐ Urinary incontinence